

OON - General - Base 1 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

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Do you offer an Out-of-Network (OON) Benefit?

Yes

No

The Maximum Plan Benefit Coverage amount for Out-of-Network Non-Medicare-covered benefits should be entered in Section D.

The Total Enrollee Out-of-Pocket Cost Limit for Out-of-Network benefits should be entered in Section D.

The Deductible for Out-of-Network benefits should be entered in Section D.

NOTE: All Out-of-Network Optional Supplemental Benefits should be entered in the Section D - Optional Supplemental Package description screens.

OON - General - Base 2 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

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Select the benefits that apply to the OON Benefits:

Medicare-covered

Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

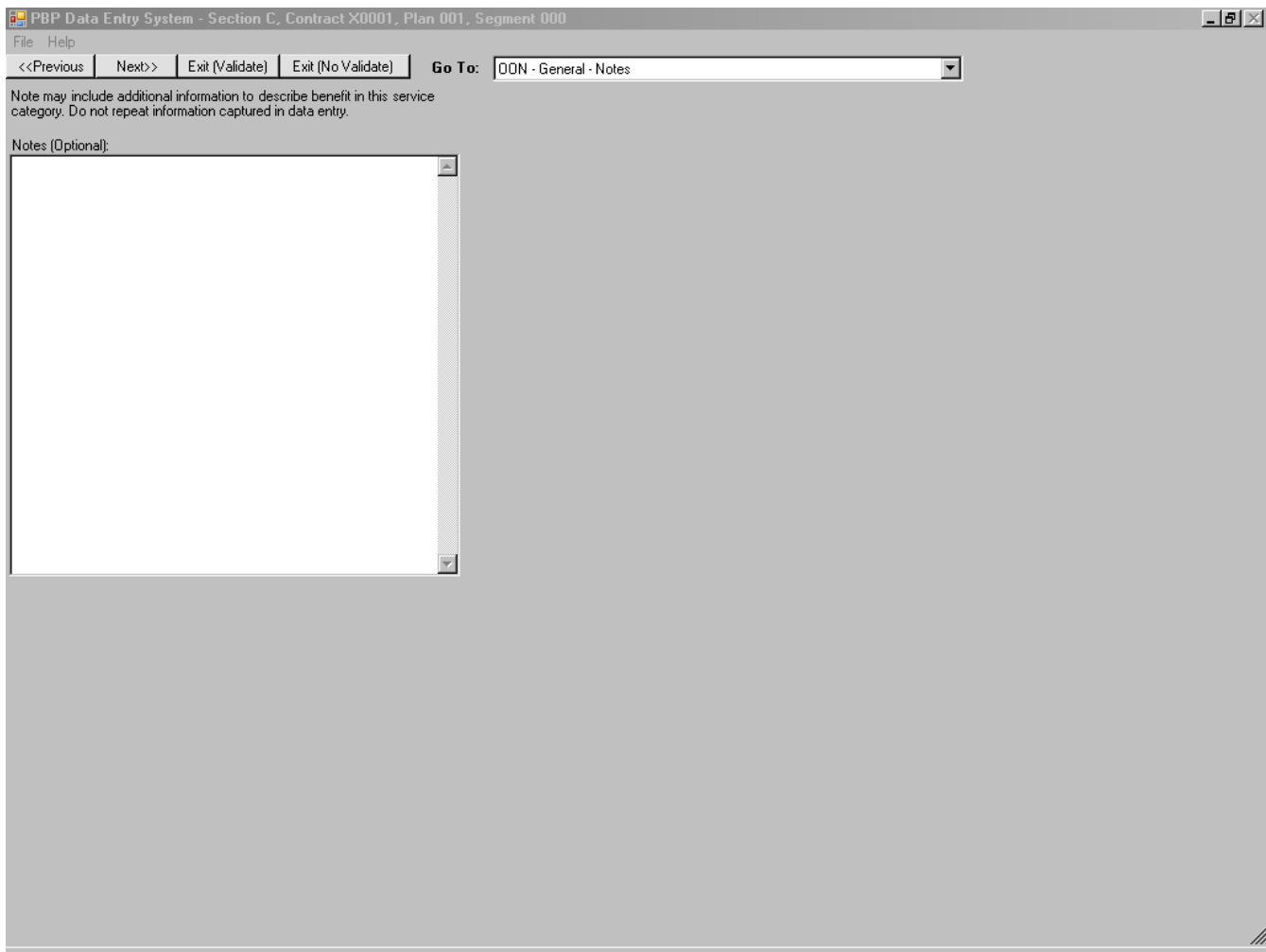
Select all of the Medicare-covered Service Categories to which the Out-of-Network benefit applies:

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:
- 9d: Outpatient Blood Services:
- 10a: Ambulance Services:
- 11a: Durable Medical Equipment (DME):
- 11b: Prosthetics/Medical Supplies:
- 11c: Diabetic Supplies and Services:
- 12: End-Stage Renal Disease:
- 14a: Medicare-covered Preventive Services:
- 14d: Kidney Disease Education Services:

Select all of the Non-Medicare-covered Service Categories to which the Out-of-Network benefit applies:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Dual Eligible SNP with Highly Integrated Services:
- 14b: Annual Physical Exam:
- 14c: Supplemental Education/Health Management Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

OON - General - Notes Screen



OON - Inpatient - Base 1 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

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Is there an enrollee Coinsurance for OON Inpatient Hospital Services?

Yes  
 No

Select the type of OON Inpatient Hospital Services Benefit with Coinsurance:

(1a) Inpatient Hospital - Acute  
 (1b) Inpatient Psychiatric Hospital

Do you charge the Medicare-defined cost shares for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate Coinsurance percentage for OON Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the OON Inpatient Hospital - Acute stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for OON Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Coinsurance % Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

OON - Inpatient - Base 2 Screen

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Do you charge the Medicare-defined cost shares for Inpatient Psychiatric Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate the coinsurance percentage and day interval(s) for OON Inpatient Psychiatric Hospital stay:

Indicate the number of day intervals for the OON Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

OON - Inpatient - Base 3 Screen

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Is there an enrollee Copayment for OON Inpatient Hospital Services?  
 Yes  
 No

Indicate Copayment amount per stay for OON Inpatient Hospital - Acute stay:

Select the type of OON Inpatient Hospital Services Benefit with Copayment:  
 (1a) Inpatient Hospital - Acute  
 (1b) Inpatient Psychiatric Hospital

Indicate the number of day intervals for the OON Inpatient Hospital - Acute stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Do you charge the Medicare-defined cost shares for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate the copayment amount and day interval(s) for OON Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

OON - Inpatient - Base 4 Screen

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Do you charge the Medicare-defined cost shares for Inpatient Psychiatric Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate Copayment amount per stay for OON Inpatient Psychiatric Hospital:

Indicate the number of day intervals for the OON Inpatient Psychiatric Hospital stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for OON Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Is there an OON Deductible for Inpatient Hospital Services?

Yes  
 No

Select the type of OON Inpatient Hospital Services benefit with a Deductible:

Inpatient Hospital - Acute  
 Inpatient Psychiatric Hospital  
 Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Enter Deductible amount for Inpatient Hospital - Acute:

Enter Deductible amount for Inpatient Psychiatric Hospital:

Enter Deductible amount for combined Inpatient Hospital Acute and Inpatient Psychiatric Hospital:

OON - SNF - Base 1 Screen

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Is there an enrollee Coinsurance for OON SNF Services?  
 Yes  
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)  
 Yes  
 No

Indicate Coinsurance percentage for OON SNF stay:

Indicate the number of day intervals for the OON SNF stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for OON SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>



OON – SNF - Base 2 Screen

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Is there an enrollee Copayment for OON SNF Services?  
 Yes  
 No

Indicate the copayment amount and day interval(s) for OON SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999).

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you charge the Medicare-defined cost shares?(These are the total charges for all services provided to the enrollee in the SNF.)  
 Yes  
 No

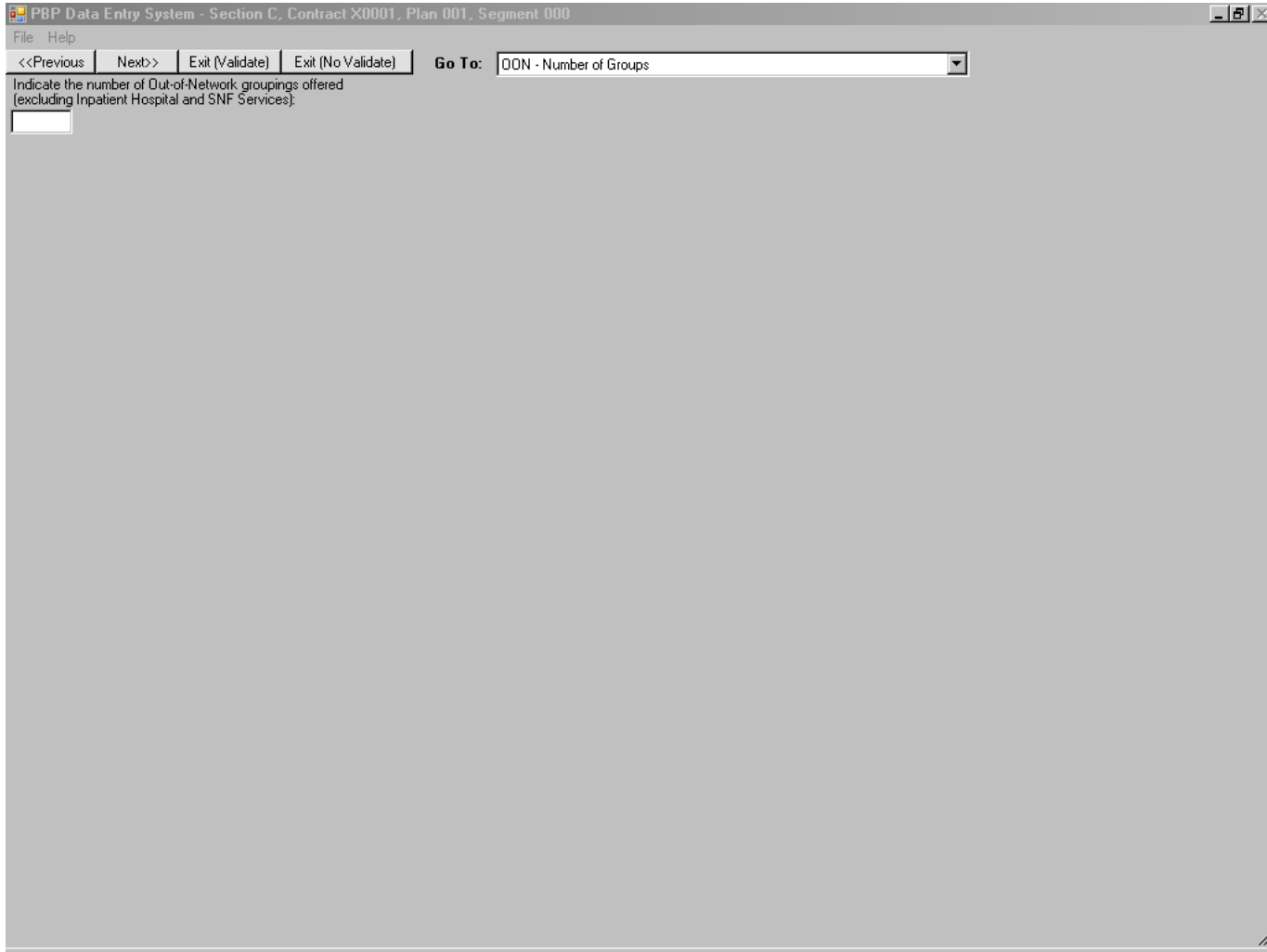
Indicate Copayment amount per stay for OON SNF stay:

Indicate the number of day intervals for the OON SNF stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Is there an OON Deductible for SNF Services?  
 Yes  
 No

Enter Deductible amount for SNF:

OON - Number of Groups Screen



OON - Groups - Base 1 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

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Enter Label for this Group (Optional):

Select the benefits that apply to the OON Groups:

Medicare-covered

Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select the Medicare-covered service categories included in the OON option for this Group:

3: Cardiac Rehabilitation Services:  
 3: Intensive Cardiac Rehabilitation Services:  
 3: Pulmonary Rehabilitation Services:  
 5: Partial Hospitalization:  
 6: Home Health Services:  
 7a: Primary Care Physician Services:  
 7b: Chiropractic Services:  
 7c: Occupational Therapy Services:  
 7d: Physician Specialist Services:  
 7e: Mental Health Specialty Services:  
 7f: Podiatry Services:  
 7g: Other Health Care Professional:  
 7h: Psychiatric Services:  
 7i: Physical Therapy and Speech-Language Pathology Services:  
 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:  
 8b1: Diagnostic Radiological Services:  
 8b2: Therapeutic Radiological Services:  
 8b3: Outpatient X-Rays:  
 9a: Outpatient Hospital Services:  
 9b: Ambulatory Surgical Center (ASC) Services:  
 9c: Outpatient Substance Abuse:  
 9d: Outpatient Blood Services:  
 10a: Ambulance Services:  
 11a: Durable Medical Equipment (DME):

Select the Non-Medicare-covered service categories included in the OON option for this Group:

3: Cardiac Rehabilitation Services:  
 3: Intensive Cardiac Rehabilitation Services:  
 3: Pulmonary Rehabilitation Services:  
 7b: Chiropractic Services:  
 7f: Podiatry Services:  
 9d: Outpatient Blood Services:  
 10b: Transportation Services:  
 13a: Acupuncture and Other Alternative Therapies:  
 13b: Over-the-Counter (OTC) Items:  
 13c: Meal Benefit:  
 13d: Other 1:  
 13e: Other 2:  
 13f: Other 3:  
 13g: Dual Eligible SNP with Highly Integrated Services:  
 14b: Annual Physical Exam:  
 14c: Supplemental Education/Health Management Programs:  
 15: Medicare Part B Rx Drugs:  
 16a: Preventive Dental:  
 16b: Comprehensive Dental:  
 17a: Eye Exams:  
 17b: Eye Wear:  
 18a: Hearing Exams:  
 18b: Hearing Aids:  
 20: Prescription Drugs (Cost Plans Only):

Is there a maximum plan benefit coverage amount for this group?

Yes

No

Indicate maximum plan benefit coverage amount:

OON – Groups - Base 2 Screen

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Is there an OON Coinsurance for this Group?

Yes  
 No

Enter Minimum Coinsurance Percentage for this Group:  
[ ]

Enter Maximum Coinsurance Percentage for this Group:  
[ ]

Is there an OON Copayment for this Group?

Yes  
 No

Enter Minimum Copayment Amount for this Group:  
[ ]

Enter Maximum Copayment Amount for this Group:  
[ ]

Is there an OON Deductible for this group?

Yes  
 No

Enter Deductible Amount for this group:  
[ ]

Indicate whether a separate physician/professional service cost share applies:

Sometimes, describe  
 No

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:  
[ ]

Indicate Maximum Coinsurance percentage for a separate physician/professional service:  
[ ]

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:  
[ ]

Indicate Maximum Copayment amount for a separate physician/professional service:  
[ ]

POS - General - Base 1 Screen

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CLICK FOR DESCRIPTION OF BENEFIT

Do you offer a Point-of-Service (POS) option?

Yes  
 No

Select type of benefit for the POS option:

Mandatory  
 Optional

Select the benefits that apply to the POS Benefit:

Medicare-covered  
 Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories that describe the POS option:

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7i: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:

Select all of the Non-Medicare-covered Service Categories that describe the POS option:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Dual Eligible SNP with Highly Integrated Services:
- 14b: Annual Physical Exam:
- 14c: Supplemental Education/Health Management Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

POS - General - Base 2 Screen

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Is there a Maximum Plan Benefit Coverage amount for POS?

Yes  
 No

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:

Medicare-covered  
 Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories that apply to the POS Maximum Plan Benefit Coverage:

1a: Inpatient Hospital Acute:  
1b: Inpatient Hospital Psychiatric:  
2: Skilled Nursing Facility (SNF):  
3: Cardiac Rehabilitation Services:  
3: Intensive Cardiac Rehabilitation Services:  
3: Pulmonary Rehabilitation Services:  
5: Partial Hospitalization:  
6: Home Health Services:  
7a: Primary Care Physician Services:  
7b: Chiropractic Services:  
7c: Occupational Therapy Services:  
7d: Physician Specialist Services:  
7e: Mental Health Specialty Services:  
7f: Podiatry Services:  
7g: Other Health Care Professional:  
7h: Psychiatric Services:  
7i: Physical Therapy and Speech-Language Pathology Services:  
8a: Outpatient Diagnostic Procedures/Tests/Lab Services:  
8b1: Diagnostic Radiological Services:

Select all of the Non-Medicare-covered Service Categories that apply to the POS Maximum Plan Benefit Coverage:

3: Cardiac Rehabilitation Services:  
3: Intensive Cardiac Rehabilitation Services:  
3: Pulmonary Rehabilitation Services:  
7b: Chiropractic Services:  
7f: Podiatry Services:  
9d: Outpatient Blood Services:  
10b: Transportation Services:  
13a: Acupuncture and Other Alternative Therapies:  
13b: Over-the-Counter (OTC) Items:  
13c: Meal Benefit:  
13d: Other 1:  
13e: Other 2:  
13f: Other 3:  
13g: Dual Eligible SNP with Highly Integrated Services:  
14b: Annual Physical Exam:  
14c: Supplemental Education/Health Management Programs:  
15: Medicare Part B Rx Drugs:  
16a: Preventive Dental:  
16b: Comprehensive Dental:

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

POS - General - Base 3 Screen

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Is there a POS Maximum Enrollee Out-of-Pocket Cost amount?

Yes  
 No

Indicate POS Maximum Enrollee Out-of-Pocket Cost:

Is there a POS Deductible?

Yes  
 No

Enter Deductible Amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

POS - General - Base 4 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - General - Base 4

Is Authorization required for POS?

Yes  
 No

Select the benefits that apply to the Authorization for POS:

Medicare-covered  
 Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories that require Authorization for POS:

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:

Select all of the Non-Medicare-covered Service Categories that require Authorization for POS:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Dual Eligible SNP with Highly Integrated Services:
- 14b: Annual Physical Exam:
- 14c: Supplemental Education/Health Management Programs:
- 15: Medicare Part B Rx Drugs:
- 16b: Comprehensive Dental:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

Enrollee must receive Authorization from one or more of the following:

None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

POS - General - Base 5 Screen



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Is a referral required for POS?

Yes  
 No

Select the benefits that apply to the POS Referral:

Medicare-covered  
 Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

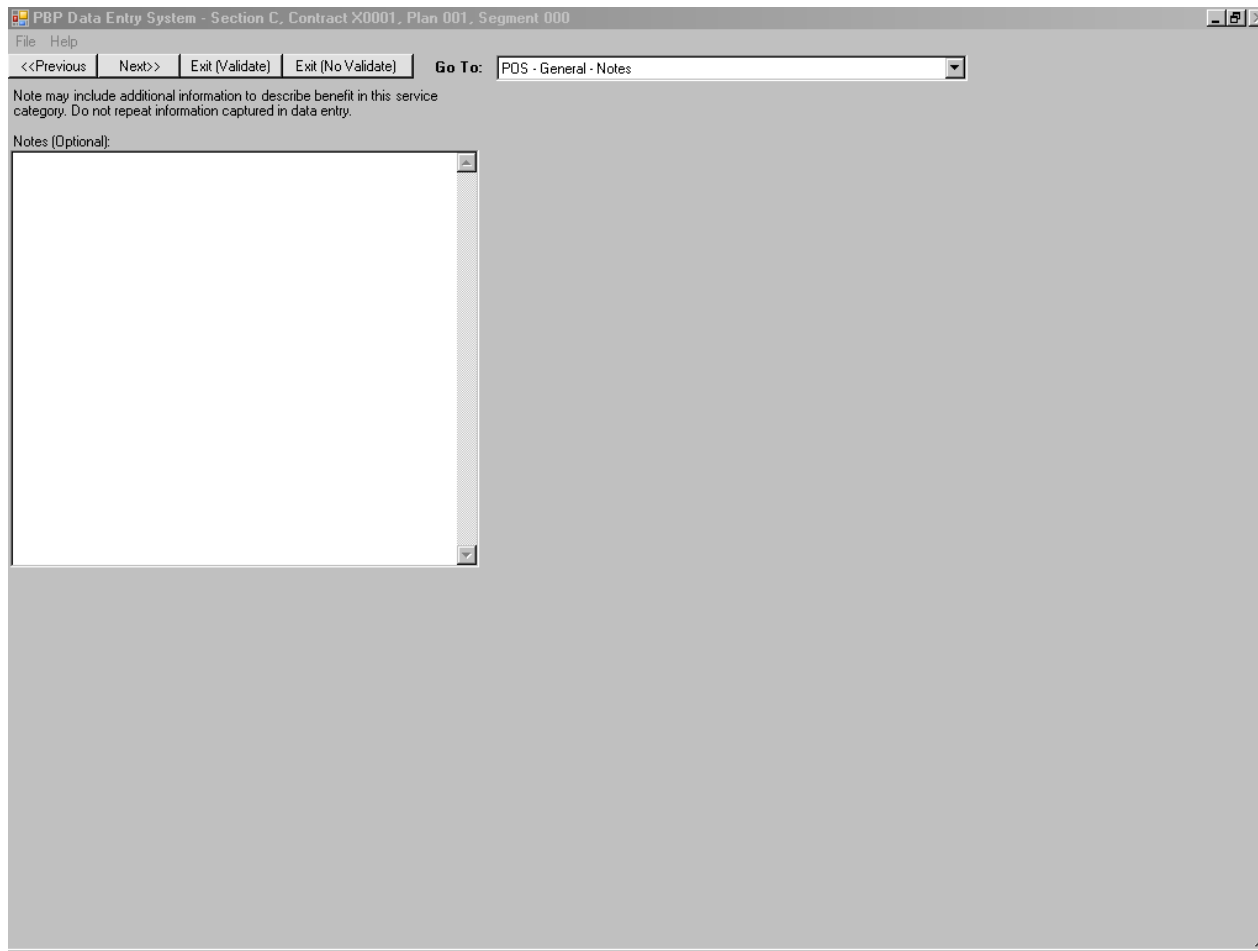
Select all of the Medicare-covered Service Categories that apply to the POS Referral:

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:

Select all of the Non-Medicare-covered Service Categories that apply to the POS Referral:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 7b: Chiropractic Services:
- 7i: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Dual Eligible SNP with Highly Integrated Services:
- 14b: Annual Physical Exam:
- 14c: Supplemental Education/Health Management Programs:
- 15: Medicare Part B Rx Drugs:
- 16b: Comprehensive Dental:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

POS - General - Notes Screen



POS - Inpatient - Base 1 Screen

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Is there a POS Maximum Plan Benefit Coverage for Inpatient Hospital Services?

Yes  
 No

Select the type of POS Inpatient Hospital Services benefit with a Maximum Plan Benefit Coverage:

Inpatient Hospital - Acute  
 Inpatient Psychiatric Hospital  
 Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Enter Maximum Plan Benefit Coverage amount for Inpatient Hospital - Acute:

Enter Maximum Plan Benefit Coverage amount for Inpatient Psychiatric Hospital:

Enter Maximum Plan Benefit Coverage amount for combined Inpatient Hospital Acute and Inpatient Psychiatric Hospital:

POS - Inpatient - Base 2 Screen

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Is there an enrollee Coinsurance for POS Inpatient Hospital Services?

Yes  
 No

Select the type of POS Inpatient Hospital Services Benefit with Coinsurance:

(1a) Inpatient Hospital - Acute  
 (1b) Inpatient Psychiatric Hospital

Do you charge the Medicare-defined cost shares for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate Coinsurance percentage for POS Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the POS Inpatient Hospital - Acute stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for POS Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

POS - Inpatient - Base 3 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Inpatient - Base 3

Do you charge the Medicare-defined cost shares for Inpatient Psychiatric Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate the coinsurance percentage for POS Inpatient Psychiatric Hospital stay:

Indicate the number of day intervals for the POS Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for POS Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

POS - Inpatient - Base 4 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Inpatient - Base 4

Is there an enrollee Copayment for POS Inpatient Hospital Services?

Yes  
 No

Select the type of POS Inpatient Hospital Services Benefit with Copayment:

(1a) Inpatient Hospital - Acute  
 (1b) Inpatient Psychiatric Hospital

Do you charge the Medicare-defined cost shares for for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate Copayment amount per stay for POS Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the POS Inpatient Hospital - Acute stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for POS Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

POS - Inpatient - Base 5 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Inpatient - Base 5

Do you charge the Medicare-defined cost shares for Inpatient Psychiatric Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes  
 No

Indicate Copayment amount per stay for POS Inpatient Psychiatric Hospital:

Indicate the number of day intervals for the POS Inpatient Psychiatric Hospital stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for POS Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Is there a POS Deductible for Inpatient Hospital Services?

Yes  
 No

Select the type of POS Inpatient Hospital Services benefit with a Deductible:

Inpatient Hospital - Acute  
 Inpatient Psychiatric Hospital  
 Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Enter Deductible amount for Inpatient Hospital - Acute:

Enter Deductible amount for Inpatient Psychiatric Hospital:

Enter Deductible amount for combined Inpatient Hospital Acute and Inpatient Psychiatric Hospital:

POS – SNF - Base 1 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - SNF - Base 1

Indicate the coinsurance percentage and day interval(s) for POS SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 399):

Is there an enrollee Coinsurance for POS SNF Services?

Yes  
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)

Yes  
 No

Indicate Coinsurance percentage for POS SNF stay:

Indicate the number of day intervals for the POS SNF stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Coinsurance % Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

POS - SNF - Base 2 Screen



PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - SNF - Base 2

Is there an enrollee Copayment for PDS SNF Services?  
 Yes  
 No

Indicate the copayment amount and day interval(s) for PDS SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you charge the Medicare-defined cost shares?(These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Copayment amount per stay for PDS SNF stay:

Indicate the number of day intervals for the PDS SNF stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Is there a PDS Deductible for SNF Services?  
 Yes  
 No

Enter Deductible amount for SNF:

POS - Number of Groups Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Number of Groups

Indicate the number of Point of Service groupings offered (excluding Inpatient Hospital Services and SNF Services):

POS - Groups - Base 1 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Groups - Base 1

Enter Label for this Group (Optional):

Select the benefits that apply to the POS Benefits for this Group:

Medicare-covered

Non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories that apply to the POS:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:

Select all of the Non-Medicare-covered Service Categories that apply to the POS:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:

Is there a POS Coinsurance for this Group?

Yes

No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there a POS Copayment for this Group?

Yes

No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

POS - Groups - Base 2 Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Groups - Base 2

Is there a POS Maximum Plan Benefit Coverage amount for this group?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
[ ]

Select the Maximum Plan Benefit Coverage periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a POS Deductible for this group?  
 Yes  
 No

Indicate Deductible amount for POS services:  
[ ]

Indicate whether a separate physician/professional service cost share applies:  
 Sometimes, describe  
 No

Is there an enrollee Coinsurance for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:  
[ ]

Indicate Maximum Coinsurance percentage for a separate physician/professional service:  
[ ]

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:  
[ ]

Indicate Maximum Copayment amount for a separate physician/professional service:  
[ ]

V/T - General - US Screen

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - General - US

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer a US Visitor/Travel Program?

Yes  
 No

Select type of benefit for the US Visitor/Travel program:

Mandatory  
 Optional

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

